

		FOR OFF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036921</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>STRIVE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/01</u> to <u>06/30/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>415 A STREET</u> <u>PROPHETSTOWN</u> <u>61277</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>WHITESIDE</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>ALAN GAPINSKI</u>																									
Telephone Number: <u>815-537-5358</u> Fax # <u>815-537-2328</u>		(Title) <u>CEO</u>																									
IDPA ID Number: <u>237136038003</u>		(Signed) _____ (Date) _____																									
Date of Initial License for Current Owners: <u>04/09/91</u>		Paid Preparer (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>																									
Type of Ownership: <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
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	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact Name: <u>ALAN GAPINSKI</u> Telephone Number: <u>815-778-3683</u>																											

STATE OF ILLINOIS

Page 2

Facility Name & ID Number STRIVE# 0036921 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds16

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,532</u>			<u>5,532</u>	13
14	TOTALS	<u>5,532</u>			<u>5,532</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.73%

D. How many bed-hold days during this year were paid by Public Aid?

308 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location

Date started 04/09/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified _____

and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAU ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	56,458	3,804	888	61,150		61,150		61,150		1
2	Food Purchase		35,930		35,930		35,930		35,930		2
3	Housekeeping	6,631	789		7,420		7,420		7,420		3
4	Laundry	734	3,789	15,750	20,273		20,273		20,273		4
5	Heat and Other Utilities			13,796	13,796		13,796	(960)	12,836		5
6	Maintenance	21,287	10,337	7,305	38,929	273	39,202		39,202		6
7	Other (specify):*										7
8	TOTAL General Services	85,110	54,649	37,739	177,498	273	177,771	(960)	176,811		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	287,826	17,219	12,943	317,988	1,229	319,217		319,217		10
10a	Therapy		51		51		51		51		10a
11	Activities	21,606	2,745	185	24,536		24,536		24,536		11
12	Social Services	28,055			28,055		28,055		28,055		12
13	Nurse Aide Training					1,230	1,230		1,230		13
14	Program Transportation		1,599		1,599	(800)	799		799		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	337,487	21,614	16,128	375,229	1,659	376,888		376,888		16
	C. General Administration										
17	Administrative			103,750	103,750		103,750	(9,046)	94,704		17
18	Directors Fees										18
19	Professional Services			12,422	12,422		12,422	673	13,095		19
20	Dues, Fees, Subscriptions & Promotion			1,488	1,488		1,488	96	1,584		20
21	Clerical & General Office Expense	28,996	2,466	3,638	35,100		35,100	807	35,907		21
22	Employee Benefits & Payroll Tax			61,592	61,592	(2,732)	58,860	11,534	70,394		22
23	Inservice Training & Education							46	46		23
24	Travel and Seminar			3,005	3,005		3,005		3,005		24
25	Other Admin. Staff Transportation							288	288		25
26	Insurance-Prop.Liab.Malpractice			6,503	6,503		6,503	45	6,548		26
27	Other (specify):*										27
28	TOTAL General Administration	28,996	2,466	192,398	223,860	(2,732)	221,128	4,443	225,571		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	451,593	78,729	246,265	776,587	(800)	775,787	3,483	779,270		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **STRIVE**

#0036921

Report Period Beginning:

07/01/01

Ending:

06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation					27,908	27,908	6,695	34,603			30
31	Amortization of Pre-Op. & Org											31
32	Interest			18,385	18,385		18,385	272	18,657			32
33	Real Estate Taxes			286	286		286		286			33
34	Rent-Facility & Grounds			28,000	28,000		28,000		28,000			34
35	Rent-Equipment & Vehicle											35
36	Other (specify): ^a			42,466	42,466	(27,908)	14,558		14,558			36
37	TOTAL Ownership			89,137	89,137		89,137	6,967	96,104			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					800	800		800			38
39	Ancillary Service Center:											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			61,065	61,065		61,065		61,065			42
43	Other (specify): ^a											43
44	TOTAL Special Cost Centers			61,065	61,065	800	61,865		61,865			44
45	GRAND TOTAL COST											
	(sum of lines 29, 37 & 44)	451,593	78,729	396,467	926,789		926,789	10,450	937,239			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(960)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,684	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotion				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 4,724		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,726		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 5,726		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 10,450		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport	X		\$ 800	38	38
39						39
40	Gift and Coffee Shop					40
41	Barber and Beauty Shop					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 800		47

STRIVE

ID# 0036921

Report Period Beginning: 07/01/01

Ending: 06/30/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number STRIVE# 0036921

Report Period Beginning:

07/01/01

Ending:

06/30/02**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(960)	0	0	0	0	0	0	0	0	0	0	(960)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(960)	0	0	0	0	0	0	0	0	0	0	(960)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	52,115	21,801	19,322	1,466	(103,750)	0	0	0	0	0	(9,046)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	551	122	0	0	0	0	0	0	0	0	673	19
20	Fees, Subscriptions & Promotions	0	96	0	0	0	0	0	0	0	0	0	96	20
21	Clerical & General Office Expenses	0	807	0	0	0	0	0	0	0	0	0	807	21
22	Employee Benefits & Payroll Taxes	0	10,769	0	0	0	0	765	0	0	0	0	11,534	22
23	Inservice Training & Education	0	46	0	0	0	0	0	0	0	0	0	46	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	288	0	0	0	0	0	0	0	0	0	288	25
26	Insurance-Prop.Liab.Malpractice	0	45	0	0	0	0	0	0	0	0	0	45	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	64,717	21,923	19,322	1,466	(103,750)	765	0	0	0	0	4,443	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(960)	64,717	21,923	19,322	1,466	(103,750)	765	0	0	0	0	3,483	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **STRIVE**# **0036921**

Report Period Beginning:

07/01/01

Ending:

06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	5,684	596	415	0	0	0	0	0	0	0	0	6,695 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	272	0	0	0	0	0	0	0	0	0	272 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	5,684	868	415	0	0	0	0	0	0	0	0	6,967 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,724	65,585	22,338	19,322	1,466	(103,750)	765	0	0	0	0	10,450 45

Facility Name & ID Number STRIVE

0036921

Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES INC	100%	BIG MEADOWS INC	SAVANNA	LYNDON PROGRESS		DAY TREATMENT
	100%	PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHABILITATION
MANAGEMENT ONLY	0.00%	WINNING WHEELS INC.	PROPHETSTOWN			
				LYNDON PLAY &		CHILD DAY CARE
				LEARN CENTER	LYNDON	
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		CHILD DAY CARE	\$ 1,889	LYNDON PLAY AND LEARN CENTER	100.00%	\$ 2,654	\$ 765	1
2	V		PROFESSIONAL SERVICES	103,750	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	108,711	4,961	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 105,639			\$ 111,365	\$ * 5,726	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number **STRIVE** # **0036921** Report Period Beginning: **07/01/01** Ending: **06/30/02**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	AMERICAN HEALTH ENTERPRISES, INC.		DIRECT						\$	1
2	ALAN GAPINSKI	PRESIDENT	MANAGEMENT	100.00						2
3	(100% OWNER OF AMREICAN HEALTH ENTERPRISES)									3
4								MANAGEMENT		4
5	S.T.R.I.V.E.			0.00	0	8	16.00	FEES	103,750	17/3 5
6	PLEASANT VIEW			100.00	0	6	12.00	"	112,577	6
7	BIG MEADOWS			100.00	0	10	20.00	"	123,673	7
8	WINNING WHEELS			0.00	0	16	32.00	"	203,250	8
9	OTHER (NON-REPORTING)			0.00	0	6	12.00	"	118,330	9
10										10
11										11
12										12
13								TOTAL	\$ 661,580	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number **STRIVE**# **0036921**Report Period Beginning: **07/01/01**Ending: **06/30/02**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization AMERICAN HEALTH ENTERPRISES, INC.
 Street Address 501 6TH AVE. WEST
 City / State / Zip Code LYNDON, IL 61261
 Phone Number (815-778-3683
 Fax Number (815-778-4503

B. Show the allocation of costs below. If necessary, please attach worksheets

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	\$ 52,115	\$ 52,115	1	\$ 52,115	1
2	17	ADMINISTRATIVE	GROSS REVENUE	10,444,000	5	252,152	252,152	903,000	21,801	2
3	17	ADMINISTRATIVE	DIRECT COST	1	1	19,322	19,322	1	19,322	3
4	17	ADMINISTRATIVE	GROSS REVENUE	10,444,000	5	16,959	16,959	903,000	1,466	4
5	19	DATA PROCESSING	GROSS REVENUE	10,444,000	5	6,368	0	903,000	551	5
6	19	ACCOUNTING	GROSS REVENUE	10,444,000	5	1,414	0	903,000	122	6
7	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	10,444,000	5	1,108	0	903,000	96	7
8	21	SUPPLIES, PHONE	GROSS REVENUE	10,444,000	5	9,334	0	903,000	807	8
9	23	TRAINING, SEMINAR	GROSS REVENUE	10,444,000	5	537	0	903,000	46	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	10,444,000	5	3,332	0	903,000	288	10
11	26	INSURANCE	GROSS REVENUE	10,444,000	5	516	0	903,000	45	11
12	30	DEPR'N VEHICLES	GROSS REVENUE	10,444,000	5	6,892	0	903,000	596	12
13	30	DEPR'N EQUIPMENT	GROSS REVENUE	10,444,000	5	4,799	0	903,000	415	13
14	32	INTEREST VEHICLES	GROSS REVENUE	10,444,000	5	3,146	0	903,000	272	14
15	22	BENEFITS	% OF SALARIES	483,938	5	70,379	0	74,052	10,769	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 448,373	\$ 340,548		\$ 108,711	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	IL HEALTH FACILITIES		X	MORTGAGE	VARIES	11/29/90	\$ 381,000	\$ 196,000	08/15/10	6.00-7.75	\$ 18,385	1	
2	FINANCING AUTHORITY											2	
3												3	
4	AMCORE BANK-				\$624.50	1/2001	30,000	24,856	01/2006	9.0000	272	4	
5	HOME OFFICE ALLOCATION		X	VEHICLES								5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$624.50		\$ 411,000	\$ 220,856				\$ 18,657	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$ 411,000	\$ 220,856				\$ 18,657	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number **STRIVE**# **0036921** Report Period Beginning: **07/01/01** Ending: **06/30/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and must accompany the cost report	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 286	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 286	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$ 286	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	NONE	8
	1998	NONE	9
	1999	NONE	10
	2000	NONE	11
	2001	NONE	12

FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY IDPH LICENSE NUMBER 0036921

TELEPHONE 815-778-3610 FAX #: 815-778-4503

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number STRIVE

0036921

Report Period Beginning:

07/01/01

Ending:

06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,022 B. General Construction Type: Exterior SIDING Frame WOOD/SPRINKLED Number of Stories 1C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☐ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1991	\$ 10,207	1
2	GARAGE/PARKING		1995-2002	21,744	2
3	TOTALS			\$ 31,951	3

Facility Name & ID Number STRIVE

0036921

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1991	1991	\$ 377,675	\$ 9,442	40	\$ 15,107	\$ 5,665	\$ 105,806	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		MIXING VALVE		1992	1,840	46	40	92	46	510	9
10		EMERGENCY LIGHTING		1992	723	18	40	18	(0)	200	10
11		LANDSCAPING		1992	1,075	27	40		(27)	299	11
12		SIDEWALK & PATIO		1993	2,578	64	40	64		652	12
13		CARPET		1993	1,690	85	10	85		1,493	13
14		STORAGE SHED		1994	2,920	146	20	146		1,326	14
15		ROADWAY		1995	2,556	183	15	183		183	15
16		PAINTING		1997	1,625	163	10	163		907	16
17		SIGN		1997	179	9	20	9		51	17
18		CARPET		1997	621	62	10	62		347	18
19		LANDSCAPING		1997	520	52	10	52		290	19
20		CARPET		1997	4,575	458	10	458		2,555	20
21		GARAGE		1997	1,608	80	20	80		449	21
22		GARAGE		1998	36,165	1,447	25	1,447		6,992	22
23		SHOWER		1998	3,322	166	20	166		747	23
24		CARPETING		1998	1,753	175	5	175		1,432	24
25		BATH ROOM TILE & SHOWERS		2000	5,386	539	10	539		1,347	25
26		SIDEWALK		2001	1,113	56	20	56		107	26
27		PARKING LOT		2001	4,972	497	10	497		829	27
28		FRONT SIDEWALK		2001	5,817	170	20	170		170	28
29		CEMENT		2001	1,066	25	40	25		25	29
30		SIDEWALKS		2001	12,478	240	40	240		240	30
31		BEAUTIFICATION		2001	8,745	437	10	437		437	31
32		STEPS		2001	1,150	20	40	20		20	32
33		DRAINAGE & GRADING		2001	4,794	140	20	140		140	33
34		SLIDING DOOR		2001	4,274	125	20	125		125	34
35		LEASEHOLD IMPROVEMENTS		2002	20,083	257	40	257		257	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

06/30/02

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

****Improvement type must be detailed in order for the cost report to be considered complete.**

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 107,955	\$ 9,672	\$ 9,672		10-15 YRS	\$ 63,830	71
72	Current Year Purchases	27,018	2,174	2,174		5-10 YRS	2,174	72
73	Fully Depreciated Assets							73
74	HOME OFFICE ALLOCATION			415	415			74
75	TOTALS	\$ 134,974	\$ 11,846	\$ 12,261	\$ 415		\$ 66,003	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MEDICAL APPOINTMENT	DODGE VAN 1992	1992	\$ 31,845				5YRS	\$ 31,845	76
77	HOME OFFICE					596	596			77
78										78
79										79
80	TOTALS			\$ 31,845		\$ 596	\$ 596		\$ 31,845	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 733,848	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,322	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,017	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,695	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 227,130	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92	REMODELLING	\$ 26,732	92
93			93
94			94
95		\$ 26,732	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: James Birklebow Trust

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>THERAPY</u>	<u>2001</u>	<u>None</u>	<u>12/2001</u>	<u>28,000</u>	<u>5</u>	<u>N/A</u>	5
6	<u>ANNEX</u>							6
7	TOTAL				\$ <u>28,000</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 12/2001

Ending 11/2006

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 6/2003 \$ 48,000

13. 6/2004 \$ 48,000

14. 6/2005 \$ 48,000

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		25		25
3	Classroom Wages (a)		340		340
4	Clinical Wages (b)		680		680
5	In-House Trainer Wage (c)		185		185
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 1,230	\$	\$ 1,230
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,230		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities:

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefit.

(c) For in-house training programs only. Do not include fringe benefit.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed
 Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis
 on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 250	\$ 580,868	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 10,089 / 95,963)	227,369	1,065,309	3
4	Supply Inventory (priced at COST)	5,130	49,137	4
5	Short-Term Investments		2,070,081	5
6	Prepaid Insurance	1,763	13,129	6
7	Other Prepaid Expenses	10,632	15,395	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): ATTACHED	(143,166)	313,579	9
	TOTAL Current Assets			
10	(sum of lines 1 thru 9)	\$ 101,978	\$ 4,107,498	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	31,951	272,861	13
14	Buildings, at Historical Cost	535,078	7,030,868	14
15	Leasehold Improvements, at Historical Cost		151,205	15
16	Equipment, at Historical Cost	166,819	1,920,081	16
17	Accumulated Depreciation (book methods)	(227,130)	(3,384,408)	17
18	Deferred Charges	4,490	8,313	18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCT IN PROGRESS	26,732	26,732	23
	TOTAL Long-Term Assets			
24	(sum of lines 11 thru 23)	\$ 537,940	\$ 6,025,652	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$ 639,918	\$ 10,133,150	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,884	\$ 58,151	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		1,682,586	29
30	Accrued Salaries Payable	27,716	179,570	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	8,609	49,698	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	REVENUE BONDS	18,000	18,000	36
37				37
	TOTAL Current Liabilities			
38	(sum of lines 26 thru 37)	\$ 71,209	\$ 1,988,005	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		482,156	40
41	Bonds Payable	178,000	178,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	RESERVE FUND BONDS	(11,610)	(11,610)	43
44	P.A. ADVANCE FOR D.T.		49,029	44
	TOTAL Long-Term Liabilities			
45	(sum of lines 39 thru 44)	\$ 166,390	\$ 697,575	45
	TOTAL LIABILITIES			
46	(sum of lines 38 and 45)	\$ 237,599	\$ 2,685,580	46
	TOTAL EQUITY(page 18, line 24)	\$ 402,319	\$ 7,447,570	47
	TOTAL LIABILITIES AND EQUITY			
48	(sum of lines 46 and 47)	\$ 639,918	\$ 10,133,150	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,447,548	1
2	Restatements (describe):		2
3	INTERFUND TRANSFER	(1,138,861)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 308,687	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	93,632	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 93,632	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 402,319	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number STRIVE

0036921

Report Period Beginning: 07/01/01

Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached**Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.**

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,021,621	1
2	Discounts and Allowances for all Levels	(1,200)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,020,421	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,020,421	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	205,498	31
32	Health Care	375,229	32
33	General Administration	223,860	33
B. Capital Expense			
34	Ownership	61,137	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	61,065	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 926,789	40
41	Income before Income Taxes (line 30 minus line 40)**	93,632	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 93,632	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **STRIVE**

0036921

Report Period Beginning: 07/01/01

Ending:

06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,046	2,222	21,606	9.72	9
10	Activity Assistants					10
11	Social Service Worker	1,859	1,901	28,055	14.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,634	6,122	56,458	9.22	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Worker	2,000	2,148	21,287	9.91	17
18	Housekeepers	559	688	7,365	10.70	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,064	2,272	28,996	12.76	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	26,677	28,441	287,826	10.12	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	40,839	43,794	\$ 451,593 *	\$ 10.31	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	18	\$ 888	1,3	35
36	Medical Director	24	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	492	9,854	10,3	38
39	Pharmacist Consultant	12	480	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	185	11,3	44
45	Social Service Consultant				45
46	Other(specify) <u>DENTIST</u>	40	2,346	10,3	46
47	<u>PSYCHOLOGICAL</u>	5	263	10,3	47
48					48
49	TOTAL (lines 35 - 48)	609	\$ 17,016		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ANNE DUNBAR				Workers' Compensation Insurance	\$ 5,863	IDPH License Fee	\$	
(SALARY INCLUDED IN MANAGEMENT FEES - LINE 17, COL. 3)				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	32,225	Health Care Worker Background Check		
				Employee Health Insurance	7,824	(Indicate # of checks performed)		
				Employee Meals		IHCA	838	
				Illinois Municipal Retirement Fund (IMRF)*		CARF RENEWAL APPLICATION	320	
				LIFE INSURANCE	1,580	DUES MES	6	
				RETIREMENT	2,888	SUBSCRIPTIONS	324	
				ST & LT DISABILITY	4,058			
				PHYSICALS	225			
				CHILD DAYCARE	1,889	Less: Public Relations Expense	()	
				RELATED PARTY ALLOCATIONS	11,534	Non-allowable advertising	()	
				EMPLOYEE MISC BENEFITS	2,308	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,	\$ 70,394	TOTAL (agree to Sch. V,	\$ 1,488	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Description			Amount	Description	Line #	Amount		
AMERICAN HEALTH ENTERPRISES			\$ 103,750					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 103,750					
(Attach a copy of any management service agreement)								
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount					
CREATIVE SOLUTIONS	MEDICAL RECORDS		\$ 1,540					
COMPUTER INTEGRATION	WEB SITE HOSTING		1,102					
INTERNET SERVICES	INTERNET SERVICES		120					
MIDWEST AUTOMATED TIME	TIME CLOCK MAINT.		400					
CDW	COMPUTER UPGRADE		409					
JOHN PYSE	COMPUTER CONSULT		2,110					
LINDGREN, CALLIHAN, VANOSI	AUDIT		6,716					
WARD, MURRAY, PACE	LEGAL		25					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 12,422					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING	8/01	\$ 4,988	5	\$	\$	\$ 499	\$ 998	\$ 998	\$ 998	\$ 988	\$ 497	\$
2													
3													
4													
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17													
18													
19													
20	TOTALS		\$ 4,988		\$	\$	\$ 499	\$ 998	\$ 998	\$ 998	\$ 988	\$ 497	\$

Facility Name & ID Number STRIVE

STATE OF ILLINOIS

0036921

Report Period Beginning: 07/01/01

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Ending: 06/30/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union NO
- (2) Are there any dues to nursing home associations included on the cost report YES
If YES, give association name and amount ILLINOIS HEALTH CARE ASSOC. \$838
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 6.5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 2,607 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease _____
- (9) Are you presently operating under a sublease agreement? YES X NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 61,065
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? NO If YES, attach an explanation of the allocation _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? NONE Indicate the amount \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation _____
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such program during this reporting period. _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period \$ NONE
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: LINDGREN, CALLIHAN & VANOSDOL CPA'S The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees _____